Assessment of Psychiatric Disorders in the Primary Care Setting: DSM5 and Beyond

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The Reconciliation of the Montagues and Capulets over the Dead Bodies of Romeo and Juliet by Frederick Leighton, 1855.

Case Vignette

A 50-year-old man with a history of 3 MDEs, but excellent response to paroxetine, and stable for the past year.

Now he states that he wants to go off the antidepressant because *"I don't want to be dependent on a medication."*

"I don't want to be addicted."

How would you address these comments?

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How do you respond?

"Are antidepressants addicting?"

- Should you wait until the patient asks?

The patient states: "I don't want to use a crutch."

- How do you address these concerns?

(Hint: Better to be early, than late)

Case Vignette

A 29-year-old woman, with recently diagnosed OCD who presents to your office for a follow-up visit.

She is very reluctant to take medications after consultation with a psychotherapist. However, she is still symptomatic from OCD.

She now states: *"I would like to take OCD meds, but **I think I am really sensitive to medications**."*

How would you address this?

Side Effects

- "No patient has ever stopped a medication because of a side effect, unless the side effect killed him." (Shea)
- Importance of *perception*

Medication Sensitivity

"Doctor, I am very sensitive to medications."

"Hey, you're really not sensitive. Those are just common side effects."

- What do you think the patient hears?
- Other potential responses?
- *"Given your sensitivity to medications, which are not uncommon by the way, I'd like to suggest that we start with a really low dose, a baby dose, of the medication. What do you think?"*

Technique: exploring medication sensitivity

1. *"Do you think you are particularly sensitive to medications?"*
2. Explore patient's perspective: *"What are some of the things that have happened that have shown you are particularly sensitive?"*
3. Do not challenge patient's perspective on medication sensitivity.
4. Ask patient permission to start at a "baby dose". Remember to give rationale.

Case Vignette

paradox of success

A 32-year-old man with bipolar disorder, type I, had been on lithium carbonate 1200mg daily for one year and doing well. His most recent labs indicated lithium level of 0.1 mEq/L.

He states: *"I am not sure I have bipolar disorder anymore."*

What are some effective responses?

Self Regulation and Testing

Self-regulation as opposed to adherence:

About half of people who are non-adherent perceive themselves as simply adjusting their own meds.

Why do people vary their medication regimes?

Self-regulation

Testing ("Am I ill?")

*alcohol

Conrad P. The Meaning of Medications: Another Look at Compliance. Soc Sci Med. 20(1), pp29-37, 1985.

Self Regulation and Testing

Paradox of success: individuals who stop the medication when they seem to be doing well:

"Do I still need it?"

Am I still ill?"

How might you forestall this kind of testing?

"When people are doing well, it's natural to wonder if the medications are still needed. Have you thought about that?"

Case Vignette

A 77yo woman is healthy except for mild hypertension and a history of chronic multiple somatic complaints, for 6m, **preoccupied with a "heavy head".**

Ongoing complaints of anxiety, decreased energy and insomnia for the past several months or years (hx is vague).
Screening neuro exam is unremarkable. Routine labs done two months ago are also noncontributory.

What else would you like to know to confirm diagnosis of somatic symptom disorder?

Somatic Symptom disorders

- Somatic symptom disorder
- Illness anxiety disorder
- Conversion disorder (functional neurological symptom disorder)
- Factitious disorder

Also,

- Psychological factors affecting other medical conditions
- Other (un-)specified somatic symptom and related disorder

Somatization Disorder

- 8 or more unexplained medical symptoms (0.5% prevalence)
- *→ Too complicated, required ruling out medical conditions*

- "Abridged somatization": 4 or more unexplained physical symptoms

4.4% prevalence in general population

22% prevalence in primary care practice

- Somatoform disorders often overlap with each other and with general medical conditions

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Somatic Symptom Disorder

A. One or more somatic sx's that are distressing or disruptive of daily life

B. Excessive thoughts, feelings, or behaviors related to the symptoms or concerns:

- Disproportionate and persistent thoughts about seriousness
- Persistent high levels of anxiety about health
- Excessive time and energy devoted to symptoms and concerns

C. Symptoms state is persistent (> 6mo)

Specify if: With predominant pain

Somatic Symptom Disorder

- May include some individuals previously diagnosed with hypochondria or somatization d/o…

…And may ALSO include those individuals with major medical illness (e.g. IDDM testing blood sugar 20 times daily)

- Usually based on a **misinterpretation** of bodily sensations

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Anxiety Illness Disorder

(includes prior diagnosis of Hypochondriasis)

A. Preoccupation with having or acquiring a serious illness.

B. Somatic Sx are absent or mild.

C. High anxiety about health, easily alarmed

D. Excessive health-related behaviors or maladaptive avoidance

E. >6m (but specific illness that is feared may change)

F. Not better explained by another disorder

Specify:
Care-seeking type
Care-avoidant type

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Conversion Disorder

(aka functional neurological symptom disorder)

- Frequently sudden onset ("hysteria")
- Symptoms may include paralysis, gait or coordination disturbance, seizures ("pseudoseizures")
- 13-30% later develop general medical condition

Somatic Symptom disorders

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Factitious Disorders

Imposed on Self: exaggerated symptoms associated with fantastic and improbable stories about travels and symptoms

Imposed on Another (by proxy): a child or other dependent is placed in sick role

Somatic Symptom disorders

	Motivation: unconscious	Motivation: conscious
Production of symptoms: unconscious	Conversion Disorder (aka functional neurological symptom disorder)	N.A.
Production of symptoms: conscious	Factitious Disorder	Malingering

Case Vignette

A 77yo woman is healthy except for mild hypertension and a history of chronic multiple somatic complaints, for 6m, **preoccupied with a "heavy head".**

ongoing complaints of anxiety, decreased energy and insomnia for the past several months or years (hx is vague).
Screening neuro exam is unremarkable. Routine labs done two months ago are also noncontributory.

What are the next best steps in management?

Management of Chronic Major Somatization*

1) Care Rather Than Cure
   - Don't try to eliminate symptoms completely
   - Focus on coping and functioning as goals of treatment

2) Diagnostic and Therapeutic Conservatism
   - Review old records before ordering tests
   - Respond to requests just as for patient who does not somatize
   - Frequent visits and physical examinations
   - Benign remedies

(Adapted from Barsky AJ. Clinical Crossroads: A 37-Year-Old Man With Multiple Somatic Complaints. *JAMA* 1997; 278: 673-9)

Management of Chronic Major Somatization*

3) Validation of Distress
   - Don't refute or negate symptoms
   - Patient-physician relationship not predicated on symptoms
   - Focus on social history
   - Regular visits (not prn) – consider scheduled telephone contacts
   - Once set, try not to alter the frequency of visits

(Adapted from Barsky AJ. Clinical Crossroads: A 37-Year-Old Man With Multiple Somatic Complaints. *JAMA* 1997; 278: 673-9)

Management of Chronic Major Somatization*

4) Providing a Diagnosis
   - Emphasize dysfunction rather than structural pathology
   - Describe amplification process and provide specific example
   - Cautious reassurance
   - Introduce stress model of disease, if appropriate

5) Psychiatric Consultation
   - To diagnose psychiatric comorbidity
   - For recommendations about pharmacotherapy
   - For cognitive-behavioral therapy to improve coping or psychotherapy

(Adapted from Barsky AJ. Clinical Crossroads: A 37-Year-Old Man With Multiple Somatic Complaints. *JAMA* 1997; 278: 673-9)

Case Vignette

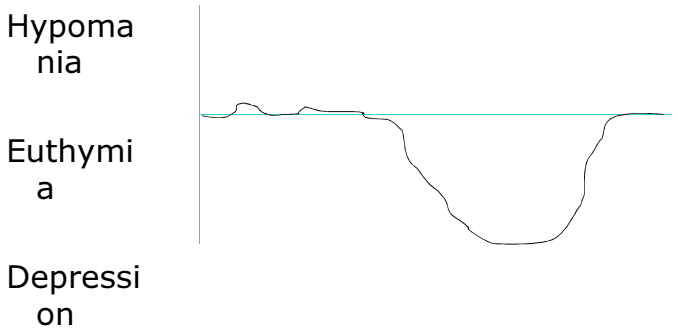
35yo man with bipolar disorder, type I

1m ago, admitted for acute mania and stabilized on lithium 600mg twice a day, olanzapine 10mg qhs and clonazepam 1mg twice a day

- 2 months ago, discharged from hospital
- Now presents with depressed mood, anhedonia, low energy, sleeping 12-14 hours per day.

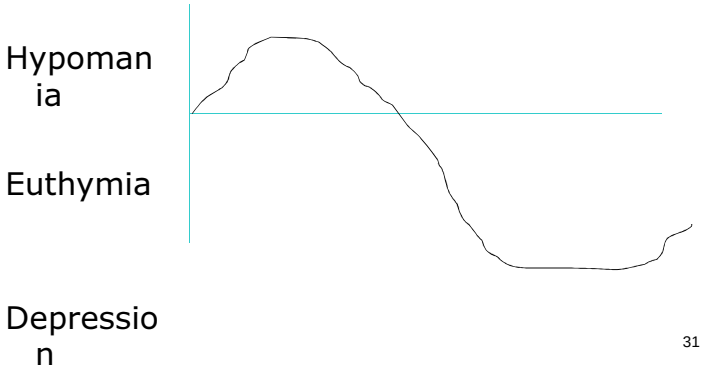
What is/are your recommendation(s)?
Does the recent manic episode influence your decision?

Spontaneous depression (easier to treat)



30

Biphasic Depression (hard to treat)



31

Clinical Pearls

- Two types of bipolar depression: spontaneous and biphasic (post-manic).
- For spontaneous depressions: try MS and lamotrigine or possibly AD that has worked well in the past.
- For post-manic depressions: watchful waiting, cont MS, individual will often recover gradually over 6-9 months*
- 70% of depressions in bipolar disorder are post-manic, hence mania prevention often cornerstone of treatment

*optimize mood stabilizer (MS), avoid antidepressants – this is hard to do.

32

How effective are antidepressants in bipolar disorder?

Results

outcome	MS+AD (n=179)	MS+placebo (n=187)	P value
Transient remission	32 (17.9%)	40 (21.4%)	0.40
Durable recovery	42 (23.5%)	51 (27.3%)	0.40
Transient remission or durable recovery	74 (41.3%)	91 (48.7%)	0.23
Affective switch (Aff switch)	18 (10.1%)	20 (10.7%)	0.84
d/c b/o adr	22 (12.3%)	17 (9.1%)	0.32
Response rate in h/o AD-related aff. switch	13.6% Aff switch = 10.2%	25.4% Aff switch = 17.9%	0.10 0.22

Bottom line: modest nonsignificant trends favoring placebo over antidepressant

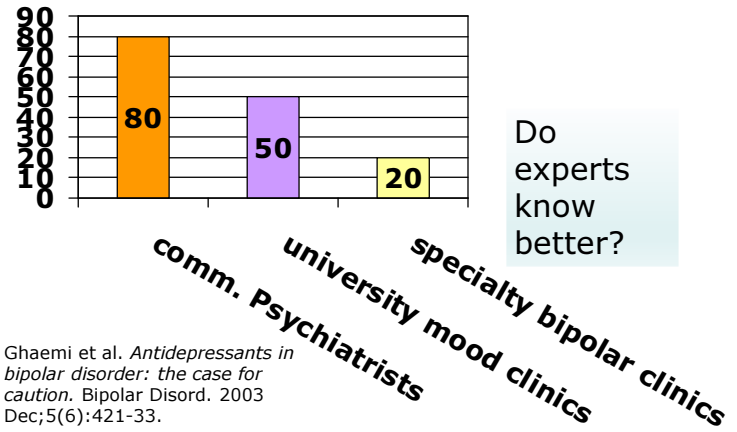
But I see many people with bipolar disorder on antidepressants, why is that?

My personal opinion is that when patients are depressed, they automatically think they should be on antidepressants.

Educating patients about antidepressants in bipolar disorder is very hard to do in an individual session.

Think psychoeducational group intervention!

Current Practice: % of patients on antidepressants



Do experts know better?

Ghaemi et al. *Antidepressants in bipolar disorder: the case for caution.* Bipolar Disord. 2003 Dec;5(6):421-33.

Take Home Points

- Remember: Two kinds of depression! (post-manic and euthymic)
- For most patients with bipolar depression, stopping or starting antidepressants don't do much
- However, if you patient has mixed features or rapid cycling, you should definitely stop antidepressants

Case Vignette: 21-year-old, single woman

Had a fight with b/f.

Took bottle of her pills

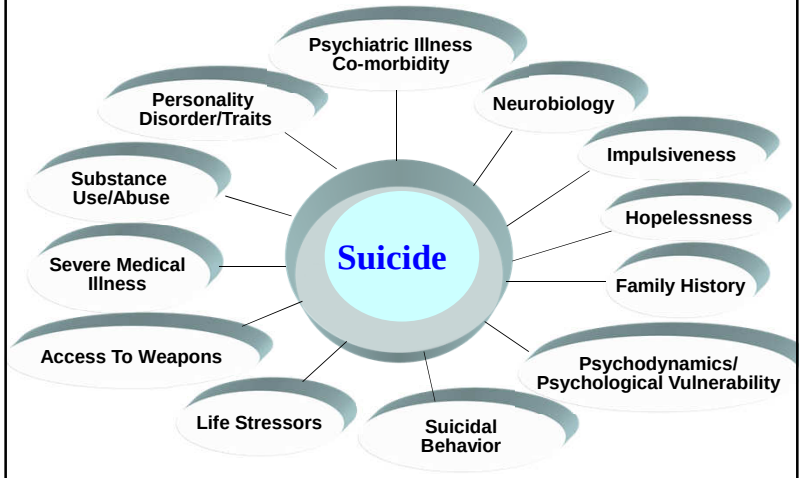
What would you like to find out?

Suicide Assessment: SAD PERSONS Mnemonic*

- **S**ex
- **A**ge
- **D**epression (especially with global insomnia, severe anhedonia, severe anxiety, agitation, and panic attacks)
- **P**revious attempt
- **E**thanol abuse (recent)
- **R**ational thought loss
- **S**ocial supports lacking
- **O**rganized plan
- **N**o spouse
- **S**ickness

The problem with risk factors…

SUICIDE: A MULTI-FACTORIAL EVENT



Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. American Journal of Psychiatry (Suppl.) Vol. 160, No. 11, November 2003

Clinical Assessment Techniques

A. Interview Techniques

1) Behavioral incident
2) Gentle assumption
3) Symptom amplification
4) Denial of the specific

We do it everyday
Pro's and con's of each

B. Collaterals

Behavioral incident

The "verbal videotape"

Was the safety on or off?

Gentle assumption

"What other ways have you thought of killing yourself?"

Symptom amplification

"How much time do you think about suicide, 80-90% of the time?"

Related to normalization and shame attenuation

Denial of the specific

List of means

- Firearms
- Drug overdose
- Hanging
- Jumping off building (or GGB)
- Cutting wrists or neck
- Carbon monoxide poisoning
- Helium asphyxiation
- Motor vehicle accident

Razors pain you;
Rivers are damp;
Acids stain you;
And drugs cause cramp.

Guns aren't lawful;
Nooses give;
Gas smells awful;
You might as well live.

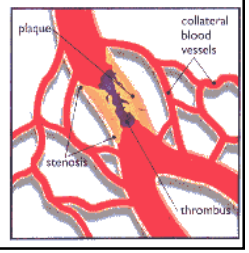
Resume, by Dorothy Parker

Clinical Assessment Techniques

A. The CASE Method
B. Interview Techniques
1) Behavioral incident
2) Gentle assumption
3) Symptom amplification
4) Denial of the specific
C. Collaterals

Collaterals

Two missions:
assess suicidality
assess quality of support



The Questions

Prior SI?
Access to means
Opinion
Support the supporter

Clinical Assessment Techniques

A. Interview Techniques

1) Behavioral incident
2) Gentle assumption
3) Symptom amplification
4) Denial of the specific

B. Collaterals

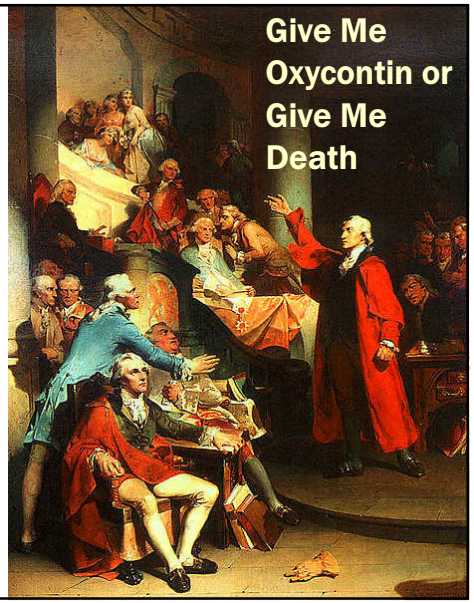
Case Vignette

The patient is a 56-year-old White male with low back pain and a history of substance abuse (mostly alcohol and marijuana). On entering the exam room, he states:

"You gotta give me some Vicodin, or I am seriously going to kill myself."

The "conditional" patient

This individual gives you an ultimatum:



The "conditional" patient

Technique: Separate "condition" from suicidal ideation

That is, evaluate and problem solve around "solution" that patient is insisting upon.

Extra Cases (if time permits)

Case vignette

52-year old-man with schizophrenia reports doing quite well with ziprasidone 160mg daily. However, he says that he has started smoking again. On evaluation, you notice that he occasionally protrudes his tongue and purses his lips.

What are possible causes of the abnormal movements?

What would you be concerned about this new presentation?

Case Vignette

A 21-year-old man with schizophrenia, most recently hospitalized 1 year ago. Starting to have AH, which are an ongoing commentary on his activities, no command.

He informs you by telephone : *"I've been off meds for the past six months and I don't want to take meds again, but I have to do something."*

How would you respond?

Hint: Think Stages of Change

Case vignette

64 year old man with anxiety and depression. Prominent somatic complaints. Multiple medication trials for depression and he has a large cache of various medications at home. Every visit he changes his meds without discussing in advance with you.

What interventions do you recommend?

Case Vignette

A 23-year-old medical student with a self-reported history of osteosarcoma and chemotherapy faints one day on rounds. She is found to be profoundly anemic. When her parents come to her apartment, they find 100s of tubes of blood.

What other information would you like to have in order to confirm a diagnosis?

What is the management of this disorder?

Case vignette

41 yo man with extraordinary concern about the safety of his wife and young daughter. He telephones home every hour. He has lost one job because of this, Six months ago, the symptoms, which have been present for years, became worse after his wife had a serious automobile accident.

He is ambivalent about medications, says: *"but I have to do something"*